	FOI	R OHF	USE		

LL1

2004 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2004)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0004	721			II. CERTI	IFICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: GENESEO GOOD SAMAR	RITAN VILLAGE				
	Address: 704 S ILLINOIS ST	GENESEO		61254	State o	ve examined the contents of the accompanying report to the fillinois, for the period fromto
	Number County: HENRY	City		Zip Code	are true	rtify to the best of my knowledge and belief that the said contents e, accurate and complete statements in accordance with able instructions. Declaration of preparer (other than provider)
	Telephone Number: (309) 944-6424	Fax # (309) 944-6605			is base	d on all information of which preparer has any knowledge.
	IDPA ID Number: 45-0228055					ntional misrepresentation or falsification of any information cost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners:	1/1/1970				(Signed)
					Officer or	(Date)
	Type of Ownership:					(Type or Print Name) Raye Nae Nylander
	x VOLUNTARY,NON-PROFIT	PROPRIETARY	COV	ERNMENTAL	of Provider	(Title) Vice President of Financial Services, CFO
	x Charitable Corp.	Individual		State		(Title) Vice i resident di Financiai Services, e Po
	Trust	Partnership		County		(Signed)
	IRS Exemption Code 501 (3)	Corporation		Other		(Date)
		"Sub-S" Corp.			Paid	(Print Name
		Limited Liability Co.	-		Preparer	and Title)
		Trust			1	,
		Other				(Firm Name
						& Address)
				(Telephone) () Fax # ()		
	In the event there are further questions about th Name: ALETA CARLSON	uis report, please contact: Telephone Number: (605) 362-3	3843			MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Spring Field H (277, 2001) Physic # (217, 782 1/20
						Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Facility Na	ıme & ID Numb	oer GENESEO G	OOD SAMARITAN	N VILLAGE			# 0004721 Report Period Beginning: 1/1/04 Ending: 12/31/04
III.	STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/o	certification level(s) of	care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed b	eds			
				_		_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							Outpatient Therapy
Bee	ds at				Licensed		
Begi	inning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? YES
Repo	ort Period	Level of C	Care	Report Period	Report Period		
				•	•		G. Do pages 3 & 4 include expenses for services or
1		Skilled (SNF	(7)	72	26,280	1	investments not directly related to patient care?
2		Skilled Pedia	atric (SNF/PED)			2	YES NO X
3		Intermediat	e (ICF)			3	_
4		Intermediat	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered Ca	are (SC)			5	YES X NO
6		ICF/DD 16 o	or Less			6	
							I. On what date did you start providing long term care at this location?
7		TOTALS		72	26,280	7	Date started <u>1/1/1971</u>
	D. C F	. 41 4	·a				J. Was the facility purchased or leased after January 1, 1978?
	B. Census-ron	the entire report per				_	YES Date NO X
	1	2	3	4	5		
Leve	d of Care	Patient Days Public Aid	by Level of Care and	d Primary Source of	Payment	-	K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified and days of care provided
8 SNF		7,696	16,573	1,200	25,469	8	of beus certified and days of care provided
9 SNF/	DED	7,090	10,5/3	1,200	25,409	9	Medicare Intermediary CAHABA
10 ICF	LED					10	Medical e filter illedial y CAHADA
10 ICF/I	DD					11	IV. ACCOUNTING BASIS
12 SC	J.D					12	MODIFIED
	6 OR LESS				1	13	ACCRUAL X CASH* CASH*
20 22 1					1	+	V.1911
14 TOT.	ALS	7,696	16,573	1,200	25,469	14	Is your fiscal year identical to your tax year? YES X NO
	C. D		P., . 14 3513 . 3	4-112			T-V 12/21/2004 F' 1V 12/21/2004
		cupancy. (Column 5, l n line 7, column 4.)	line 14 divided by to 96.91%	tai iicensed			Tax Year: 12/31/2004 Fiscal Year: 12/31/2004 * All facilities other than governmental must report on the accrual basis.
	bea days of	inic 7, column 4.)	70.71 /0	_			An inclines which than governmental must report on the accidan basis,

STAT	TT C	ALC I	тт	TNI	α	c
SIAI	H. C) P				۹

Page 3 12/31/04 Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 **Report Period Beginning:** 1/1/04 **Ending:**

	V. COST CENTER EXPENSES (through				llar)					TOD OTTO		
	0 1 7		osts Per Genera	-		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHE	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	_		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	166,982	13,195	6,268	186,445		186,445	(252)	186,193			1
2	Food Purchase		143,374		143,374		143,374	(1,370)	142,004			2
3	Housekeeping	84,100	15,171		99,271		99,271	(128)	99,143			3
4	Laundry	66,222	9,354		75,576		75,576	(44)	75,532			4
5	Heat and Other Utilities			78,886	78,886		78,886	(536)	78,350			5
6	Maintenance	79,891	13,056	59,658	152,605		152,605	(1,622)	150,983			6
7	Other (specify):*			9,105	9,105		9,105		9,105			7
8	TOTAL General Services	397,195	194,150	153,917	745,262		745,262	(3,952)	741,310			8
	B. Health Care and Programs											4
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,188,845	111,382	4,257	1,304,484		1,304,484	(24,854)	1,279,630			10
10a	Therapy	4,092	367	83,677	88,136		88,136	(38,401)	49,735			10a
11	Activities	60,733	9,126	3,695	73,554		73,554	(212)	73,342			11
12	Social Services	42,431	140	1,106	43,677		43,677	(2)	43,675			12
13	Nurse Aide Training											13
14	Program Transportation			3,736	3,736		3,736		3,736			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,296,101	121,015	97,671	1,514,787		1,514,787	(63,469)	1,451,318			16
	C. General Administration											
17	Administrative	36,573		132,310	168,883		168,883	18,858	187,741			17
18	Directors Fees											18
19	Professional Services			3,090	3,090		3,090		3,090			19
20	Dues, Fees, Subscriptions & Promotions			31,167	31,167		31,167	(10,774)	20,393			20
21	Clerical & General Office Expenses	82,024	20,909	31,030	133,963		133,963	(11,861)	122,102			21
22	Employee Benefits & Payroll Taxes			359,891	359,891		359,891	(12,043)	347,848			22
23	Inservice Training & Education			21,997	21,997		21,997	(2,654)	19,343			23
24	Travel and Seminar			2,674	2,674		2,674	(206)	2,468			24
25	Other Admin. Staff Transportation			,	ŕ		1	` '				25
26	Insurance-Prop.Liab.Malpractice			45,239	45,239		45,239	(5,128)	40,111			26
27	Other (specify):* Marketing & Res Dev	11,806		7,179	18,985		18,985	(12,178)	6,807			27
28	TOTAL General Administration	130,403	20,909	634,577	785,889		785,889	(35,986)	749,903	_		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,823,699	336,074	886,165	3,045,938		3,045,938	(103,407)	2,942,531			29

**Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			156,321	156,321		156,321	(20,871)	135,450			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			9,094	9,094		9,094		9,094			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,359	3,359		3,359		3,359			35
36	Other (specify):*											36
37	TOTAL Ownership			168,774	168,774		168,774	(20,871)	147,903			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,447	39,447		39,447		39,447			42
43	Other (specify):*			2,219	2,219		2,219	(2,219)				43
44	TOTAL Special Cost Centers			41,666	41,666		41,666	(2,219)	39,447			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,823,699	336,074	1,096,605	3,256,378		3,256,378	(126,497)	3,129,881			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

0004721

Report Period Beginning:

12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	3	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,37)			4
5	Telephone, TV & Radio in Resident Rooms	(53)	5) 5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,44)	0) 6		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,774	4) 20		25
	Income Taxes and Illinois Personal				
26					26
	Nurse Aide Training for Non-Employees				27
	Yellow Page Advertising	(114.65)			28
	Other-Attach Schedule	(114,67)	/		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (129,79)	J)	\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

Ending:

			-	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	3,293		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,293		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (126,497)		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.) 1 2

3

4

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS

Page 5A

GENESEO GOOD SAMARITAN VILLAGE
ID# 0004721

Report Period Beginning: 1/1/04
Ending: 12/31/04

Sch. V Line

	NON-ALLOWABLE EXPENSES		Amount	Reference	
1	ACTIVITY	\$	(69)	11	1
2	POSTAGE		(6)	21	2
3	UNIFORM INC		(3,537)	21	3
4	GLUCOSE STRIP EXP		(1,004)	10	4
5	DEFERRED MAINT COSTS - 1997-1999		301	6	5
6	DEFERRED MAINT COSTS - 2000-2001		1,109	6	6
7	DEPRECIATION EXP - APT AND DUPLEX		(20,871)	30	7
8					8
9	PROCLAIM OFFSET		(2,461)	10	9
10	PRESCR DRUGS - REIMB		(20,464)	10	10
11	SALARIES - RES DEV		(5,856)	27	11
12	VAC ACC - RES DEV		(58)	27	12
	CONTRACT - RES DEV		(36)	27	13
14	SUPPLIES - RES DEV		(3,000)	21	14
15	SM RQUIP - RES DEV		(302)	21	15
	MISC FDRAISERS EXP		(6,808)	21	16
17	TRAVEL - RES DEV		(206)	24	17
18	STAFF DEV - RES DEV		(2,654)	23	18
	SALARIES - MARKETING		(5,856)	27	19
20	P/SERV-LABORATORY-MDCR		(2,219)	43	20
	THERAPY OFFSET - PT, OT, ST		(38,401)	10a	21
	EQUIPMENT REPAIRS - RES DEV		(294)	6	22
23	NEWSLETTERS - RES DEV		(372)	27	23
_	FICA - MARKETING		(211)	22	24
	FICA - RES DEV		(1,395)	22	25
26			()===)		26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34		-			34
35		-			35
36		-			36
37		-			37
38		-			38
39		-			39
40		-			40
41		+			41
42		+			42
43		+			43
44		+			43
45		-			44
46		-			45
46		-			
_		-			47
48	T-4-1	_	(444.070)		48
49	Total		(114,670)	l	49

STATE OF ILLINOIS Summary A # 0004721 Report Period Beginning: 1/1/04 12/31/04 **Ending:**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE SUMMARY OF PAGES 5. 5A, 6. 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6I	(to Sch V, col	.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,370)	0	0	0	0	0	0	0	0	0	0	(1,370)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(536)	0	0	0	0	0	0	0	0	0	0	(536)	5
6	Maintenance	(1,324)	0	0	0	0	0	0	0	0	0	0	(1,324)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,230)	0	0	0	0	0	0	0	0	0	0	(3,230)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(23,929)	0	0	0	0	0	0	0	0	0	0	(23,929)	10
10a	Therapy	(38,401)	0	0	0	0	0	0	0	0	0	0	(38,401)	10a
11	Activities	(69)	0	0	0	0	0	0	0	0	0	0	(69)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(62,399)	0	0	0	0	0	0	0	0	0	0	(62,399)	16
	C. General Administration													
17	Administrative	0	18,858	0	0	0	0	0	0	0	0	0	18,858	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(10,774)	0	0	0	0	0	0	0	0	0	0	(10,774)	20
21	Clerical & General Office Expenses	(13,653)	0	0	0	0	0	0	0	0	0	0	(13,653)	21
22	Employee Benefits & Payroll Taxes	(1,606)	(10,437)	0	0	0	0	0	0	0	0	0	(12,043)	22
23	Inservice Training & Education	(2,654)	0	0	0	0	0	0	0	0	0	0	(2,654)	23
24	Travel and Seminar	(206)	0	0	0	0	0	0	0	0	0	0	(206)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(5,128)	0	0	0	0	0	0	0	0	0	(5,128)	26
27	Other (specify):*	(12,178)	0	0	0	0	0	0	0	0	0	0	(12,178)	27
28	TOTAL General Administration	(41,071)	3,293	0	0	0	0	0	0	0	0	0	(37,778)	28
20	TOTAL Operating Expense (sum of lines 8.16 & 28)	(106,700)	2 202	0	0	0	0	•	0	0	0	0	(103,407)	20
29	(Sum of times 5.10 & 28)	(100,/00)	3,293	U	U	U	0 1	U		U	U	U	(103,407)	1 29

STATE OF ILLINOIS

Summary B Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6I	(to Sch V, col	.7)
30	Depreciation	(20,871)	0	0	0	0	0	0	0	0	0	0	(20,871)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(20,871)	0	0	0	0	0	0	0	0	0	0	(20,871)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,219)	0	0	0	0	0	0	0	0	0	0	(2,219)	43
44	TOTAL Special Cost Centers	(2,219)	0	0	0	0	0	0	0	0	0	0	(2,219)	44
	GRAND TOTAL COST			·										
45	(sum of lines 29, 37 & 44)	(129,790)	3,293	0	0	0	0	0	0	0	0	0	(126,497)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Effet below the harnes of ALE owners and related organizations (parties) as defined in the instructions. Attach an additional schedule in necessary.									
1	•		2		•	3			
OWNERS		RELATED NURSING HOMES			OTHER RELATED BUSINESS ENTITIES				
Name	Ownership %	Name		City		Name	City		Type of Business
		,,,,,							
B. Are any costs included in this repo	ort which are a result	of transactions wit	h related organizations? This inclu	des rent,					

management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
					-	Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	17	Admin Acctg	\$ 132,310		100.00%	\$ 151,168		1
2	V		Workers comp	47,954			39,804	(8,150)	2
3	V	22	Unemploy Charges Paid	3,514			3,414	(100)	3
4	V		Insurance	45,237			40,109	(5,128)	4
5	V	22	Group Health Ins	126,042			123,855	(2,187)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 355,057			\$ 358,350	\$ * 3,293	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7 GENESEO GOOD SAMARITAN VILLAGI 0004721 **Report Period Beginning:** 1/1/04 12/31/04 Facility Name & ID Number **Ending:**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Hou	ırs Per Work				
					Compensation	Week Dev	oted to this	Compensati	on Included	Schedule V.	
					Received		l % of Total	in Costs		Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	NOT APPLICABLE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

ST/	ATE.	OF	TT 1	IN	OIG

Page 8 Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			1				\$		\$	1
2						NO ALLOCATION	NECESSARY			2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10			-							10 11
12										12
13										13
14			<u> </u>							14
15										15
16										16
17										17
18										18
19										19 20
20										20
21										21
22										22 23
23										23
24										24
25	TOTALS					\$	\$		 \$	25

GENESEO GOOD SAMARITAN VILLAGE

0004721

Report Period Beginning:

1/1/04

Ending:

Page 9 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE T	AX EXPENSI

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	ì	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amor Original	int of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related			•						•	
	Long-Term										
1	NOT APPLICABLE					\$	\$			\$	1
2											2
3											3
4											4
5											5
	Working Capital										
6											6
7											7
8											8
9	TOTAL Facility Related	-				s	\$			\$	9
10	B. Non-Facility Related*				I	I		Ī			10
10		 									10 11
11		 									12
13		 									13
13											13
14	TOTAL Non-Facility Related	_				\$	\$			\$	14
15	TOTALS (line 9+line14)					\$	\$			\$	15

16)	Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$ Line #

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0004721 Report Period Beginning: 1/1/04 Ending: 12/31/04

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

D. Real Estate Taxes					
Real Estate Tax accrual used on 2003 report.	Important , please see the next worksheet, bill must accompany the cost report.	, "RE_Tax". The real	estate tax statement and	s	1
2. Real Estate Taxes paid during the year: (Indicate the ta	x year to which this payment applies. If payment cov	ers more than one year, de	tail below.)	s	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2004 report. (Detail	and explain your calculation of this accrual on the line	es below.)		s	4
5. Direct costs of an appeal of tax assessments which has (Describe appeal cost below. Attach copies	•			s	5
6. Subtract a refund of real estate taxes. You must offset classified as a real estate tax cost plus one-half of any TOTAL REFUND \$ For	, 11	eal estate tax appeal	board's decision.)	s	6
7. Real Estate Tax expense reported on Schedule V, line	33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year: 1999	4,066 8		FOR OHF USE ONLY		
2000 2001	9	13	FROM R. E. TAX STATEMENT FO	OR 2003 \$	13
2002 2003	11 12	14	PLUS APPEAL COST FROM LINI	E5 \$	14
		15	LESS REFUND FROM LINE 6	\$	15
-	·	16	AMOUNT TO USE FOR RATE CA	ALCULATION \$	16

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILI	TY NAME GENESEO GOOD	O SAMARITAN VILLAGE	COUNTY	HENRY
FACILI	TY IDPH LICENSE NUMBER	0004721		
CONTA	CT PERSON REGARDING THIS	REPORT		
TELEPH	HONE ()	FAX #:	()	
	ımmary of Real Estate Tax Cost			
Er co ho	nter the tax index number and real east that applies to the operation of the operation of the property which is vacant, rente tered in Column D. Do not include	ne nursing home in Column D. Rea d to other organizations, or used fo	al estate tax applicable to r purposes other than lon	any portion of the nursing
	(A)	(B)	(C)	(D)
2			Total Tax S S S S S S S S S S S S S S	\$ \$
		TOTALS	\$	\$
В. <u>R</u>	eal Estate Tax Cost Allocations			
us If	oes any portion of the tax bill apply ted for nursing home services? YES, attach an explanation & a scl Generally the real estate tax cost mu	YES	NO of the cost allocated to the	he nursing home.
`	ax Bills	st oc anocated to the mursing nome	oasea upon sq. 1t. 01 spa	cc uscu.)

 $Attach\ a\ copy\ of\ the\ original\ 2003\ tax\ bills\ which\ were\ listed\ in\ Section\ A\ to\ this\ statement.\ Be\ sure\ to\ use\ the\ 2003$

tax bill which is normally paid during 2004.

Page 10A

					STATE OF	FILLINOIS	;				Page 11
	ity Name & ID Number GENI				#	0004721	Report Period Beginning:		1/1/04	Ending:	12/31/04
X. B	UILDING AND GENERAL IN	FORMAT	ION:								
A.	Square Feet:	22,848	B. General Construction Type:	Exterior	BRICK		Frame	Nu	mber of Sto	ories	
C.	Does the Operating Entity?		X (a) Own the Facility	(b) Rent from	a Related O	rganization			nt from Con ganization.	npletely Unre	lated
	(Facilities checking (a) or (b)	must com	plete Schedule XI. Those checking (c)	may complete Schedu	ıle XI or Sch	edule XII-A	. See instructions.)				
D.	Does the Operating Entity?		X (a) Own the Equipment	(b) Rent equi	pment from a	Related O	rganization.	(c) Ren Unr	nt equipment related Orga	nt from Comp anization.	oletely
	(Facilities checking (a) or (b)	must com	plete Schedule XI-C. Those checking	(c) may complete Scho	edule XI-C o	Schedule X	XII-B. See instructions.)				
Е.	(such as, but not limited to, a	partments	this operating entity or related to the assisted living facilities, day training re footage, and number of beds/units	facilities, day care, in	dependent li						
	DUPLEXES - 21 UNITS										
F.	Does this cost report reflect : If so, please complete the following		cation or pre-operating costs which a	re being amortized?			YES	NO NO			
1.	. Total Amount Incurred:				2. Number	of Years O	ver Which it is Being Amor	tized:			
3.	. Current Period Amortization	: -			— 4. Dates In	curred:		•			
		_									
		N	lature of Costs:	:::	-f	·					
			(Attach a complete schedule deta	ining the total amount	oi organizat	ion and pre-	-operating costs.)				
XI. C	OWNERSHIP COSTS:										
		_	1	2		3	4				
	A. Land.	<u> </u>	Use	Square Feet	Year	Acquired	Cost	1			
		-	1			1969	\$ 26,000	1 2			
		F	3 TOTALS				\$ 26,000	3			
		<u> </u>					•				

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 000

XI. OWNERSHIP COSTS (continued)

R. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to pearest dollar.

0004721

Report Period Beginning:

1/1/04 Ending:

Page 12 12/31/04

	B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	72		1971	1971	\$ 494,740	\$ 12,369	40	\$ 12,369	\$	\$ 417,437	4
5											5
6											6
7											7
8											8
	Improv	ement Type**									
9	BUILDING	J.F.									9
10				1977	1,100		VARIES			1,100	10
11				1978	7,629		20			7,629	11
12				1981	168,876	5,451	VARIES	5,451		133,442	12
13				1982	2,299		VARIES			2,299	13
14				1986	2,926	15	VARIES	15	0	2,910	14
15				1987	15,313	520	VARIES	520		14,013	15
16				1988	124,091	5,286	VARIES	5,286		104,956	16
17				1989	26,987	561	VARIES	561		26,202	17
18				1990	108,416	5,229	VARIES	5,229		78,508	18
19				1991	3,157	53	VARIES	53		3,072	19
20				1992	36,755	1,204	VARIES	1,204		30,173	20
21				1993	37,071	648	VARIES	648		34,132	21
22				1994	69,096	3,695	VARIES	3,695		48,506	22
23				1995	76,363	4,713	VARIES	4,713		45,343	23
24											24
25											25
26 27											26
											27
28 29											28 29
30											30
31											31
32											32
33								 	ļ		33
34							-	-			34
35							-	-			35
36											36
50				1		1	1	I	1	1	50

See Page 12A, Line 70 for total

^{*}Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

0004721 Report Period Beginning:

Page 12A 12/31/04 1/1/04 Ending:

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equipment. (S	see msu ucuons.) Kounu	an numbers to near	est uonar.	6	7	8	1 0	1
1	Year	4	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation 1	in Years	Depreciation	Adjustments	Depreciation	
1 11	Collsti ucteu	Cust	e	III I Cars	e Depreciation	Aujustinents	S	37
BUILDING CONTINUED	1996	107	5	20	5	3	48	38
38 CERAMIC FLOORING/BATHROOM QA-M			3	20	3			
39 LAUNDRY WALL PROTECTION	1996	1,109					1,109	39
40 ACTIVITY ROOM REMODEL/SINK	1996	2,132					2,132	40
41 LAUNDRY DOORS Q/A	1996	1,874	125	15	125		1,103	41
42 BATHROOM SINK	1996	678	34	20	34		302	42
43 AWNING FOR REHAB CLINIC	1996	983	98	10	98		860	43
44								44
45 KEMLITE IN CLOSETS	1996	653	65	10	65		566	45
46 POWER ACCESS DOOR OPERATOR	1996	1,009	101	10	101		875	46
47 GENERATOR/MOVE TO GSS	1996	3,431	343	10	343		2,973	47
48 CARPET FOR PARLOR	1996	2,627		5			2,499	48
49 A/C-ROOF TOP ON 200 WING	1996	229	15	15	15		130	49
50 ELECTRIC-REMODEL PARLOR	1996	186	9	20	9		79	50
51 BUILDING-REMODEL PARLOR	1996	1,132	57	20	57		481	51
52 PLUMBING-REMODEL PARLOR	1996	599	30	20	30		255	52
53 WALLPAPER-REMODEL PARLOR	1996	2,645		5			2,517	53
54 SHOWER REMODEL-GRAB BARS	1996	1,321	132	10	132		1,090	54
55 REPLACE FIXTURES/FLOOR/WALL	1996	3,955	198	20	198		1,615	55
56 WINDOWS	1996	25,212	1,681	15	1,681		13,727	56
57 BUILDING-REMODEL	1996	1,692	85	20	85		712	57
58 WINDOW FOR DINING ROOM	1997	1,650	110	15	110		871	58
59 300 WING CEILING TILE WORK	1997	2,584		5			2,584	59
60 WALL BUILT IN LAUNDRY ROOM	1997	1,013	101	10	101		802	60
61 WINDOWS	1997	5,100	340	15	340		2,692	61
62 WALLPAPER FOR JACK ANDREWS	1997	2,221		5			2,221	62
63 CARPET FOR CONFERENCE ROOM	1997	2,192		5			2,192	63
64 CONFERENCE ROOM WORK	1997	1,350	135	10	135		1,069	64
65 WALL PROTECTION	1997	739		5			739	65
66 NEW SPRINKLERS FOR OFFICE	1997	909	91	10	91		697	66
67 WALLPAPER-RESIDENT ROOM 308	1997	2,667 #		5			2,667	67
68 CARPET FOR RESIDENT ROOM	1997	506		5			506	68
69								69
70 TOTAL (lines 4 thru 69)	S	1,247,324	\$ 43,499		\$ 43,499	s 0	\$ 999,835	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

0004721 Report Period Beginning:

Page 12B
Period Beginning: 1/1/04 Ending: 12/31/04

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Year Current Book Life Straight Line Accumulated Improvement Type** Constructed Cost Depreciation in Years Depreciation Adjustments Depreciation 1 Totals from Page 12A, Carried Forward 1,247,324 43,499 43,499 999,835 2 BUIDLING CONTINUED 1,059 1,059 8,383 4 ROOF-FRONT ENTRY 21,178 1,392 5 SOCIAL SERVICE & CONFERENCE TOOM 6 D.O.N. & STAFF DEVELOPMENT OFFICE 1,236 7 WALLPAPER-ROOM 308 1,440 1,440 8 DRAIN/SEWER WORK 1,464 9 REMODEL WORK IN ROOM 309 10 SIDERAIL 1/2 DELUXE 11 SIDERAILS 12 DRYWALL-NURSE STATION 13 REHAB WALL WORK 14 REROOFING 64,129 3,206 3,206 22,979 18,510 5,183 15 BUILDING-REMODEL NURSES STATION 16 CARPET-REMODEL NURSES STATION 1,753 1,753 17 WALLCOVERING-REMODEL NURSES STATION 1,794 1,794 18 FORM & POUR LAMP POST BASES 19 SIDE RAILS 1,242 20 KITCHEN DOOR 21 CABINETRY & INSTALLATION 1,282 3,799 2,532 22 ROOM 204 WORK 1,709 1,367 23 VINYL COVERING-KICK PLATES 24 HANDRAIL & INSTALLATION 25 FIRE ALARM SYSTEM WORK 1,090 26 BATHROOM FIXTURES 27 ROOF FLASHING INSTALLATION 1,008 28 KOROGUARD IN MED ROOM AND BATH 30 GENERATOR 47,534 16,043 2,377 2,377 31 BOILER TANK 3,803 593 2,472 32 DOOR FRAME GUARDS 34 TOTAL (lines 1 thru 33) 1,429,607 52,791 52,791 1,072,229

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

XI. OWNERSHIP COSTS (continued)

0004721 Report Period Beginning:

Page 12C eriod Beginning: 1/1/04 Ending: 12/31/04

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Year Current Book Life Straight Line Accumulated Improvement Type** Constructed Cost Depreciation in Years Depreciation Adjustments Depreciation 1 Totals from Page 12B, Carried Forward 1,429,607 52,791 52,791 1,072,229 2 BUILDING CONTINUED 2 3 WATER HEATER 1998 1.339 134 10 134 3 1,398 1,398 1998 4 4 FLOORCOVERING CEILING TILE 1998 996 5 RESIDENT ROOM WORK 5 1,027 6 CEILING TILE 1998 1998 20,525 20 1,027 6 6.817 341 20 341 2,130 2000 PROJECT 8 BATHROOM WORK 10 8 1998 2,121 212 212 1,325 15 1,624 9 9 AIR CONDITIONING 1998 24,279 1,624 9,799 10 HVAC SYSTEMS 4,284 15 10 1998 287 287 1,729 11 ALUMINUM ENTRANCE/AMBULANCE 1999 1,726 115 15 115 681 11 12 ROOF WORK 1999 2,800 280 10 280 1,563 12 13 13 14 WOOD SIGN 10 177 14 1999 2,350 235 10 235 1,312 15 15 HVAC SYSTEMS 237 237 16 PLUMBING-BATHROOM REMODEL 1999 4,739 20 1,343 16 17 BUILDING-REMODEL RESIDENT ROOM 1999 6,265 251 25 251 1,296 17 18 18 DRAPES-REMODEL RESIDENT ROOM 5 1999 279 47 47 279 1999 197 10 20 10 51 19 19 ELECTRIC-REMODEL RESIDENT ROOM 2,697 449 449 2,697 20 PAINT/REMODEL RESIDENT ROOM 1999 5 20 21 22 FAUCETS 1,159 20 266 22 23 OAK CABINETS FOR KITCHEN 1,603 15 23 2000 2000 107 107 24 LAUNDRY REPAIR 533 107 5 107 24 25 26 26 27 27 28 28 WATER SOFTENER 2000 541 54 10 54 221 29 MAINTENANCE GARAGE
30 BLDG-REDECORATE 300 WING COORD 5,314 2001 79,709 5,314 15 20,370 29 2001 8,062 322 25 322 1,129 30 31 CARPET-REDECORATE 300 WING 2001 2001 1,986 414 397 1,390 31 10 32 FIRE ALARM CONTROL PANEL 41 41 138 32 33 34 TOTAL (lines 1 thru 33) 1,606,753 64,473 64,473 1,130,890 34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

0004721 Report Period Beginning:

1/1/04 Ending:

Page 12D 12/31/04

B. Building Depreciation-Including Fixed Equipment. (See inst	ructions.) Roun	d all numbers to near	est dollar.					
1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 1,606,753	\$ 64,473		\$ 64,473	\$ 0	\$ 1,130,890	1
2 BUILDING CONTINUED								2
3 WORK ON HEAT UNITS	2001	3,856	386	10	386		1,189	3
4 FURNACE	2001	508	51	10	51		152	4
5 LAMINATE CABINETS-ACT.ROOM	2002	2,779	185	15	185		525	5
6 PHONE CABLE WIRING TO ROOMS	2002	700	70	10	70		187	6
7 AIR CONDITIONERS-BUILDING A	2002	6,175	617	10	617		1,749	7
8 BUILDING -REMODEL RESIDENT RMS	2002	32,873	1,315	25	1,315		3,506	8
9 CAULKING-REMODEL RESIDENT RMS	2002	193	19	10	19		51	9
10 CERAMIC TILE-REMDL RESIDENT RM	2002	181	9	20	9		24	10
11 CORNER GUARD-REMDL RESIDENT RM	2002	90	9	10	9		24	11
12 DRAPES-REMDL RES RM	2002	1,152	230	5	230		614	12
13 DRAPERY RODS-REMDL RES RM	2002	174	17	10	17		46	13
14 WALLPAPER-REMDL RES RM	2002	1,809	362	5	362		965	14
15 BLINDS-REMDL RESIDENT RM	2002	533	107	5	107		285	15
16 CAPET-THERAPY	2002	622	124	5	124		270	16
17 BUILDING-REDECORATE 100/200	2002	11,911	476	35	476		1,112	17
18 CARPET-REDECORATE 100/200	2002	5,069	1,014	5	1,014		2,365	18
19 CORNER GUARDS-REDEC 100/200	2002	170	17	10	17		40	19
20 DOORS-REDECORATE 100/200	2002	199	13	15	13		31	20
21 WALLPAPER-REDECORATE 100/200	2002	1,905	381	5	381		889	21
22								22
23 SOLID CORE DOORS/SNF	2003	1,656	110	15	110		202	23
24								24
25 LIGHTING FIXTURES	2003	6,755	676	10	676		901	25
26								26
27 BLDG-REMODEL	2003	5,173	207	25	207		293	27
28 WINDOWS	2003	2,494	166	15	166		194	28
29 DUAL SENSOR SMOKE ALARM	2003	1,276	128	10	128		138	29
30								30
31 TILE FOR DIETARY OFFICE	2004	775	65	10	65		65	31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,695,781	\$ 71,227		\$ 71,227	\$ 0	\$ 1,146,707	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

0004721 Report Period Beginning:

Page 12E riod Beginning: 1/1/04 Ending: 12/31/04

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Year **Current Book** Life Straight Line Accumulated Constructed Improvement Type** Cost Depreciation in Years Depreciation Depreciation Adjustments 1 Totals from Page 12D, Carried Forward 1,695,781 71,227 71,227 1,146,707 2 BUILDING CONTINUED: 2 3 REPAIR DINING ROOM ROOF 2004 3,253 217 10 217 217 3 4 5 BLINDS-RESIDENT ROOM REMODEL 2004 1,257 21 21 21 5 25 6 BUILDING-RESIDENT ROOM REMODEL 23,806 6 7 DRAPES-RESIDENT ROOM REMODEL 5 8 ELECTRIC-RESIDENT ROOM REMODEL 2004 1,109 20 8 2004 9 9 WALLPAPER-RESIDENT ROOM RMDEL 88 10 10 11 11 12 12 13 14 14 15 15 16 17 16 18 18 19 19 20 20 21 21 22 22 23 24 25 23 24 25 26 26 27 27 28 29 28 29 30 30 31 31 32 32 34 TOTAL (lines 1 thru 33) 1,725,360 71,551 71,551 1,147,031 34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

0004721

Report Period Beginning:

Page 12F 12/31/04 1/1/04 Ending:

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equipment. (S	see msn acnons.) Rouna	An numbers to near	est uonar.	6	7	1 8	9	
1	Year	7	Current Book	Life	Straight Line	0	Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12E, Carried Forward	Constructed	1,725,360	\$ 71,551	III Tears	\$ 71,551		\$ 1.147.031	1
2 LAND IMPROVEMENTS		1,723,300	φ /1,551		71,551	3	1,147,031	2
	1971	9,171		15			9,171	3
3 DRIVES-GRADING-WALKS	1971	5,865		15			5,865	-3
4 BLACKTOP								4
5 PAVING	1974	3,499		15			3,499	5
6 IMPROVE WEST SIDE OF PARKING	1975	1,018		15			1,018	6
7 DIRT-EE SNODGRASS	1975	83		15			83	-7
8 RESURFACE PARKING LOT	1978	3,817		15			3,817	8
9 SIDEWALK AROUND CENTER-DRAIN	1981	3,842		20			3,796	9
10 SOD AROUND BLDG	1981	1,450		10			1,450	10
11 PAVING-ASPHALT	1985	6,089		15			6,089	11
12 PARKING LOT CHESTNUT STREET	1988 1990	62,030		15			62,030	12 13
13 DEMOLITION OF HOUSES	1990	2,985		10			2,985	
14 LANDSCAPE	1990	69	5/1	10	5/1		69	14
15 GAZEBO		11,223	561	20	561		7,435	15
16 ISABEL BLOOM FOR MEMORIAL	1992	300	20	15	20		250	16
17 ILLUMINA TED SIGN BOX AND COVE	1992	5,288	294	12	294		5,288	17
18 TO LAY BRICKS FOR NEW SIGN	1992	383	24	12	24		383	18 19
19 LANDSCAPING MATERIAL	1992 1995	2,764	(41	10	C/11		2,764	
20 GAZEBO		9,618	641	15	641		5,931	20
21 FENCE	1995	6,242	416	15	416		3,849	21
22 BURY ELECTRIC LINE	1996	3,347	335	10	335		2,984	22
23	1007	2.050	1.42	20	142		1.003	23
24 GAZEBO	1997	2,850	143	20	143		1,093	24 25
25 WALK	1997	2,500	167	15	167		1,277	
26 ENTRANCE AREA LANDSCAPING	1997	2,450	245	10	245		1,817	26 27
27 SPRINKLER SYSTEM	1997	726	48	15	48		343	
28 PARKING LOT CHESTNUT STREET	1997	2,265	113	20	113		821	28
29 COURTHOUSE RESEARCH FOR PREP	1998	515	52	10	52		356	29
30 PATIO	1998	1,313	131	10	131		843	30
31 SKYLIGHT & FLASHING WORK	1998	1,607	161	10	161		1,031	31
32 SEED	1990	803		10			803	32
33		4 000 400					4.004.454	33
34 TOTAL (lines 1 thru 33)	S	1,879,472	\$ 74,902		\$ 74,902	\$ 0	\$ 1,284,171	34

 $^{{\}rm **Improvement\ type\ must\ be\ detailed\ in\ order\ for\ the\ cost\ report\ to\ be\ considered\ complete}.$

0004721 Report Period Beginning:

Page 12G 1/1/04 Ending: 12/31/04

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Year **Current Book** Life Straight Line Accumulated Constructed Improvement Type** Cost Depreciation in Years Depreciation Depreciation Adjustments 1 Totals from Page 12F, Carried Forward
2 LAND IMPROVEMENTS CONTINUED 1,879,472 74,902 74,902 1,284,171 3 SIDEWALK 1,128 4 BLOCKS/RETENTION POND 5 FENCING AROUND SCREEN 1,520 6 PARKING LOT LAMP POSTS 839 7 STRIPING PARKING LOT 3,564 PARKING LOT EXPANSION 13,797 13 17 24 25 24 25 29 29 34 TOTAL (lines 1 thru 33) 1,897,739 75,940 75,940 1,288,694

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

CT/	TE	OF	TT	T	NOI	(
3 I A	A I P.	T)F			7()	ю

Page 13 Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE 0004721 **Report Period Beginning:** 1/1/04 12/31/04 **Ending:** XI. OWNERSHIP COSTS (continued)

C. 1	Equi	pment l	Deprec	iation-	Exclu	ling	Trans	portation.	(See	instruct	ions.)
-------------	------	---------	--------	---------	-------	------	-------	------------	------	----------	-------	---

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 562,130	\$ 49,095	\$ 49,095	\$		\$ 425,345	71
72	Current Year Purchases	26,906	2,405	2,405			2,405	72
73	Fully Depreciated Assets	265,843					265,843	73
74								74
75	TOTALS	\$ 854,879	\$ 51,500	\$ 51,500	\$		\$ 693,593	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76	RESIDENT CARE	TRUCK	1994	\$ 3,000	\$	\$	\$	2	\$ 3,000	76
77		REBUILDING TRUCK	1996	3,596				4	3,596	77
78		19 PASSENGER VAN	1998	46,953	2,007	2,007		3	46,953	78
79		WHEELCHAIR BELTS FOR	R VA 2003	795	199	199		4	282	79
80	TOTALS			\$ 54,344	\$ 2,206	\$ 2,206	\$		\$ 53,831	80

E. Summary of Care-Related Assets

		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,832,962	81	1
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 129,646	82	1
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 129,646	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84	1
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,036,118	85	1

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book		Accumulated	
	Description & Year Acquired	Cost	Depreciation	3	Depreciation 4	
86	LAND	\$ 160,693	\$		\$	86
87	BUILDING	3,384,719	118	,589	720,009	87
88	LAND IMP	82,847	3.	,687	31,531	88
89	FFE	93,267	3.	,646	65,510	89
90						90
91	TOTALS	\$ 3,721,526	\$ 125.	.922	\$ 817,050	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 397,340	92
93			93
94			94
95		\$ 397,340	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

			STATE OF	ILLINOIS				Page 13	
Facility Nam	ne & ID Number GENESEO	GOOD SAMARITAN VILLAGE	0004721	Report Period E	Beginning:	1/1/04	Ending:	12/31/04	
XI. OWNER	RSHIP COSTS (continued)								-
	C. Equipment Depreciation-Excluding	Transportation. (See instructions.)							
	Category of	1		Current Book	Straight Line	4	Component	Accumulated	
1		~ .					~		1

	C. Equipment Depreciation Excitaing	ransportation. (See mistrate	tions.)						
	Category of	1		Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Co	st	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$		\$	\$	\$ 0		\$	71
72	Current Year Purchases					0		0	72
73	Fully Depreciated Assets					0		0	73
74						0			74
75	TOTALS	\$	0	\$ 0	\$ 0	\$ 0		\$ 0	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired	3 Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76	RESIDENT CARE	2004 DODGE RAM TRUCK	2003	\$ 20,807	\$ 3,468	\$ 3,468	\$ 0	6	\$ 3,468	76
77		SNOWPLOW ON VEHICLE	2004	3,359	770	770	0	4	770	77
78		CHRYSLER MINIVAN	2000	13,700	1,522	1,522	0	6	1,522	78
79							0			79
80	TOTALS			\$ 37,866	\$ 5,760	\$ 5,760	\$ 0		\$ 5,760	80

E. Summary of Care-Related Assets Reference Amount

81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,961,605	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,700	82	J
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,700	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84	J
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,294,454	85	
					_

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Accumulate	ed
	Description & Year Acquired	Cost	Depreciatio	n 4
86		\$	S	86
87				87
88				88
89				89
90				90
91	TOTALS	\$		91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

STATE OF ILLINOIS

						STATE OF ILLIN	OIS					Page 14
Faci	lity Name & II) Number	GENESEO GOOD	SAMARITAN V	/ILLAGE	# 0004721	l	Report Period	Beginning:	1/1/04	Ending:	12/31/04
XII.	1. Name of P 2. Does the f	nd Fixed Equip Party Holding L		,	mount shown below on l	line 7, column 4?	NO					
		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Year of Lease	6 Total Ye Renewal O _I					
3	Original Building:			S				3		dates of current		ment:
4	Additions							4	Ending			
5								5				
6	mom. v							6		e paid in future	years under t	he current
7	TOTAL			\$	**			7	rental agr	eement:		
	This amou		tization of lease expense ted by dividing the totale						Fiscal Year 12. 13.	/2005 /2006	Annual Ros	ent
	9. Option to	Buy:	YES	NO T	erms:		•		14.	/2007	\$	
	B. Equipment 15. Is Movab	t-Excluding Tra	ansportation and Fixed rental included in build	l Equipment. (Se ling rental?	ee instructions.)	YES	X NO					
	16. Rental A	mount for mov	able equipment: \$	3,359	Description:	NETWORK COM						
						(Attach a sch	edule detailing the	e breakdown	of movable equipn	ient)		
	C. Vehicle Re	ntal (See instru										
	1		2 Model Year	M	3 Conthly Lease	4 Rental Exp	onco					
	Use		and Make	141	Payment	for this Per			* If there	is an option to	buy the buildi	ing.
17	0.00			\$		\$	17			rovide complet		
18							18		schedul	ė.		
19				_			19					
20				-			20			ount plus any a		
21	TOTAL			\$		\$	21		expense	must agree wit	<u>th page 4, line</u>	34.

- schedule.
- ** This amount plus any amortization of lease expense must agree with page 4, line 34.

				TATE OF ILLI	NOIS						Page 15
		D SAMARITAN VILLAC			#	0004721	Report Perio	od Beginning:	1/1/04	Ending:	12/31/04
XIII. EXI	PENSES RELATING TO NURSE AIDE TRAINI	NG PROGRAMS (See in	structions.)								
A. T	YPE OF TRAINING PROGRAM (If aides are tr	ained in another facility J	orogram, attach a	schedule listing t	he facility	name, address	and cost per	aide trained in th	at facility.)		
	1. HAVE YOU TRAINED AIDES DURING THIS REPORT	X YES 2.	CLASSROOM	PORTION:			3.	CLINICAL POL	RTION:	_	
	PERIOD?	NO	IN-HOUSE PR	OGRAM				IN-HOUSE PRO	OGRAM		
	If "yes", please complete the remainder		IN OTHER FA	CILITY				IN OTHER FAC	CILITY		
	of this schedule. If "no", provide an explanation as to why this training was		COMMUNITY	COLLEGE	X			HOURS PER A	IDE		
	not necessary.		HOURS PER A	AIDE	108						
В. Е	XPENSES	ALLOCATION	ON OF COSTS	(4)			C. CO	NTRACTUAL IN	COME		
		ALLOCATIO	ON OF COSTS	(d)				In the hear heless		c : .	
		1	2	3		4		In the box below facility received			
		Fac	cility			•	7	incine, received	v. ug u.u		111011111001
		Drop-outs	Completed	Contract		Total	1	\$			
1	Community College Tuition	\$ 556	\$	\$	\$	556	1			_	
2	Books and Supplies	16				16	D. NU	MBER OF AIDES	TRAINED		
3	Classroom Wages (a)	896				896	1				
4	Clinical Wages (b)							COMPLET	ED		
5	In-House Trainer Wages (c)							1. From this faci	lity		

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

1,468

1,468

- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

6 Transportation

TOTALS

Contractual Payments

Nurse Aide Competency Tests

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

1,468

2. From other facilities (f)

2. From other facilities (f)
TOTAL TRAINED

DROP-OUTS

1. From this facility

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

GENESEO GOOD SAMARITAN VILLAGE

LINOIS Page 16
Report Period Beginning: 1/1/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	(1	2	3	4	5	6	7	8	
		Schedule V	Staff		Outsid	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other tl	han consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	\$ NOT APPLICA	BLE	\$	\$		\$ #VALUE!	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

	_	1		2 After	
$ldsymbol{ld}}}}}}}}}$		0	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	49,218	\$	1
2	Cash-Patient Deposits		3,910		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance		431,592		3
4	Supply Inventory (priced at)		9,091		4
5	Short-Term Investments		1,810,875		5
6	Prepaid Insurance		24		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	2,304,710	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		160,693		13
14	Buildings, at Historical Cost		5,110,079		14
15	Leasehold Improvements, at Historical Cost		306,138		15
16	Equipment, at Historical Cost		1,040,356		16
17	Accumulated Depreciation (book methods)		(2,838,506)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds		65,512		21
22	Other Long-Term Assets (specify):				22
23	Other(specify): Asset Manage, CIP		400,961		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	4,245,233	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	6,549,943	\$	25

		1 Or	erating	2 After Consolidation*	
	C. Current Liabilities	O _F	crating	Consolidation	
26	Accounts Payable	\$	88,464	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		3,910		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		218,801		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)				31
32	Accrued Real Estate Taxes(Sch.IX-B)		106,025		32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Group Ins, Garnishments		(565)		36
37	Security		(9,386)		37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	407,249	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43	Refd-Dplx Ent Fee, Non Refd-Dplx Ent	Fe	1,715,499		43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	1,715,499	\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	2,122,748	\$	46
47	TOTAL FOURTV(nego 18 Bno 24)	\$	4,427,195	\$	47
4/	TOTAL EQUITY(page 18, line 24) TOTAL LIABILITIES AND EQUITY		4,447,173	Ф	4/
48	=	\$	6 540 042	s	48
48	(sum of lines 46 and 47)	Þ	6,549,943	3	48

1/1/04

Page 17

12/31/04

Ending:

^{*(}See instructions.)

0004721 Report Period Beginning: 1/1/04

Ending:

1	Balance at Beginning of Year, as Previously Repor
2	Restatements (describe):
3	CONGREGATE

71 01	IANGES IN EQUIT I		1	
			Total	
1	Balance at Beginning of Year, as Previously Reported	\$	4,173,110	1
2	Restatements (describe):			2
3	CONGREGATE		19,733	3
4	APARTMENTS		20,378	4
5	DUPLEXES		50,325	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	4,263,546	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		238,670	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe) DNR RST PROP, OPER, OPER GFT-GRA	AN'	17,909	15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	256,579	17
	B. Transfers (Itemize):			
18	CASH ASSET ASSESS, DNR RST END-GEN		(92,933)	18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$	(92,933)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	4,427,192	24

^{*} This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 3,552,663	1
2	Discounts and Allowances for all Levels	(514,270)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,038,393	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	1,558	5
6	Therapy	229,985	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 231,543	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	768	12
13	Barber and Beauty Care	1,201	13
14	Non-Patient Meals	1,369	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	24,410	16
17	Sale of Drugs	58,641	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,842	19
20	Radiology and X-Ray	50	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 88,281	23
	D. Non-Operating Revenue		
	Contributions	14,251	24
25	Interest and Other Investment Income***	95,435	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 109,686	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NSG & MED SUPPLIES	31,022	28
28a	SCHD ATTACHED	(3,877)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,145	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,495,048	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	745,262	31
32	Health Care	1,548,364	32
33	General Administration	752,312	33
	B. Capital Expense		
34	Ownership	168,774	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	41,666	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,256,378	40
41	Income before Income Taxes (line 30 minus line 40)**	238,670	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 238,670	43

*	This mus	t agree with	page 4,	line 45, colum	n 4.
---	----------	--------------	---------	----------------	------

*	Does this agree wit	th taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

1/1/04

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

	(This schedule must cover the	entire reportin				
		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,864	2,147	\$ 53,649	\$ 24.99	1
2	Assistant Director of Nursing	196	198	4,084	20.63	2
3	Registered Nurses	9,202	10,090	185,494	18.38	3
4	Licensed Practical Nurses	9,009	9,792	151,176	15.44	4
5	Nurse Aides & Orderlies	63,934	71,387	742,838	10.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	192	194	4,092	21.09	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,804	2,150	27,176	12.64	9
10	Activity Assistants	4,039	4,414	33,600	7.61	10
11	Social Service Workers	2,475	2,785	41,198	14.79	11
12	Dietician					12
	Food Service Supervisor	1,970	2,143	28,933	13.50	13
14	Head Cook	5,608	5,989	57,202	9.55	14
15	Cook Helpers/Assistants	9,248	10,578	81,618	7.72	15
16	Dishwashers					16
17	Maintenance Workers	6,340	6,920	79,785	11.53	17
	Housekeepers	8,594	9,584	83,451	8.71	18
19	Laundry	6,030	6,829	65,293	9.56	19
20	Administrator	1,203	1,341	36,220	27.01	20
21	Assistant Administrator					21
22	Other Administrative	2,039	2,333	36,049	15.45	22
23	Office Manager	1,303	1,436	19,182	13.36	23
24	Clerical	2,011	2,172	25,961	11.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,633	2,975	42,034	14.13	31
32	Other Health Care(specify)		ĺ	, and the second		32
	Other(specify) Market/Res Dev	786	866	11,712	13.52	33
34	TOTAL (lines 1 - 33)	140,480	156,323	\$ 1,810,747 *	s 11.58	34

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	114	\$ 5,249	Ln 1, Col 3	35
36	Medical Director	12	1,200	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,726	Ln 10, Col 3	39
40	Physical Therapy Consultant	2,342	42,496	Ln 10a, Col 3	40
41	Occupational Therapy Consultant	1,443	24,361	Ln 10a, Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	130	5,741	Ln 10a, Col 3	43
44	Activity Consultant	18	1,175	Ln 11, Col 3	44
45	Social Service Consultant	18	1,175	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,077	s 85,123		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53
	•		•	•	

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

	STA	TE	OF	ILL	INO	IS
--	-----	----	----	-----	-----	----

Report Period Beginning:

1/1/04

0004721

XIX. SUPPORT SCHEDULES A. Administrative Salaries Ownership D. Employee Benefits and Payroll Taxes F. Dues, Fees, Subscriptions and Promotions Description Name Function % Description Amount Amount Amount **IDPH License Fee** Mike Olsen Administrator 100 36,220 Workers' Compensation Insurance 39,804 **Unemployment Compensation Insurance** 3,414 Advertising: Employee Recruitment Health Care Worker Background Check FICA Taxes 138,131 Vacation Accrual 353 **Employee Health Insurance** 123,854 (Indicate # of checks performed Employee Meals Publications - Reimb, SS 903 Illinois Municipal Retirement Fund (IMRF)* Public Relations - Reimb 5,773 900 8,409 Taxable Gifts Pmts Dues - Reimb TOTAL (agree to Schedule V, line 17, col. 1) Staff Pension 38,210 Advert/Promo - Admin, Res Dev/Mark 15,992 (List each licensed administrator separately.) Newsletter - Admin Newsletter - Marketing 36,573 3,298 90 B. Administrative - Other Less: Newsletter - Marketing **Employees Physicals 87** (90)Less: Public Relations Expense Admin/Consultant Savings 1,756 FICA - Res Dev, Marketing Non-allowable advertising (10,684)Description Amount (1,606)Admin/Acctg Serv 132,310 Yellow page advertising TOTAL (agree to Schedule V, 347,848 TOTAL (agree to Sch. V, 20,393 line 22, col.8) line 20, col. 8) TOTAL (agree to Schedule V, line 17, col. 3) 132,310 E. Schedule of Non-Cash Compensation Paid G. Schedule of Travel and Seminar** (Attach a copy of any management service agreement) to Owners or Employees C. Professional Services Description Amount Vendor/Pavee Description Line# Type Amount Amount Out-of-State Travel 1,092 64360 National Campus **DRC Energy Consulting** 252 64360 Accu-Med Sevices Inc JCAHO fee 450 58000 RK Dixon Company 102 Contract - toner, cartridge In-State Travel 805 64360 National Campus 786 Survey Fees 64540 National Campus Medicare Cost Report Prep 700 64541 National Campus Medicaid Cost Report Prep 800

GENESEO GOOD SAMARITAN VILLAGE

Facility Name & ID Number

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$2500 attach copy of invoices.)

TOTAL

3,090

TOTAL

Seminar Expense

Less: Res Dev Travel

Entertainment Expense

(agree to Sch. V,

line 24, col. 8)

Page 21

12/31/04

777

(206)

2,468

Ending:

^{*} Attach copy of IMRF notifications

^{**}See instructions.

Report Period Beginning:

1/1/04

Ending:

Page 22 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2001	FY2002	FY2003	Amount of FY2004	Expense Amor	rtized Per Year FY2006	FY2007	FY2008	FY2009
1	PAINT & LABOR	1/97	\$ 1,539	5	\$ 308	\$ 25	\$	\$	\$	\$	\$	\$	\$
2	PAINT	3/97	23	5	4	4							
3	PAINT	4/97	37	5	7	4							
4	PAINT	5/97	45	5	9	4							
5	PAINT	1/98	283	5	57	55							
6	WALLPAPER	3/98	362	5	72	72	20						
7	PAINT	4/98	343	5	69	69	22						
8	WALLPAPER	5/98	723	5	145	145	60						
9	WALLPAPER	6/98	38	5	15	15	11						
10	PAINT	7/98	65	5	13	13	6						
11	PAINT	8/98	361	5	72	72	43						
12	PAINT	10/98	75	5	15	15	11						
13	PAINT	12/98	864	5	173	173	158						
14	PAINT	2/99	1,800	5	360	360	360	60					
15	PAINT	3/99	4,032	5	806	806	806	203					
	PAINT	4/99	97	5	19	19	19	8					
17	PAINT PT ROOM	7/99	44	5	9	9	9	4					
18	PAINT & LABOR	8/99	10	5	2	2	2	1					
19	PAINT	9/99	130	5	26	26	26	20					
20	TOTALS		\$ 10,871		\$ 2,181	\$ 1,888	\$ 1,553	\$ 296	s	\$	\$	\$	\$

STATE OF ILLINOIS	Page 22

		GENESEO GOOD SAMARITAN VILLAGE				# 0004721			Report Period Beginning: 1/1/0		1/1/04	Ending:	12/31/04
	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year					Amount of Expense Amortized Per Year						
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT	11/99	\$ 34	5	\$ 7	\$ 7	\$ 7	\$ 5	\$	\$	\$	\$	\$
2	WALLPAPER	7/00	1,295	5	259	259	259	259	130				
3	WALLPAPER/PAINT	12/00	_,	5	506	507	507	507	464				
4	PAINT	6/00	64	5	13	13	13	12	6				
5	PAINT	2/01	496	5	91	105	105	105	91				
6	PAINT	6/01	348	5	35	93	93	93	34				
7	PAINT	6/01	120	5	12	32	32	32	12				
8	PAINT	6/01	192	5	19	51	51	51	20				
9	PAINT	8/01	70	5	4	21	21	21	4				
10	PAINT	8/01	68	5	4	20	20	20	4				
11	PAINT	8/01	30	5	1	9	9	9	2				
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,250		\$ 951	\$ 1,117	\$ 1,117	\$ 1,114	\$ 767	\$	\$	\$	\$

			OF ILLINOIS				Page 23
	y Name & ID Number GENESEO GOOD SAMARITAN VILLAGE	7	# 0004721	Report Period Beginning:	1/1/04	Ending:	12/31/04
	ENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union? NO	(13)	the Department of	supplies and services which are of the Public Aid, in addition to the daily ra			
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	(1.1)	•	ection of Schedule V? YES			C
(3)	Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?	(14)	the patient census is a portion of the	building used for any function other listed on page 2, Section B? NO building used for rental, a pharmacy, explains how all related costs were al	day care, etc.	For example) If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?	(15)	Indicate the cost of on Schedule V. related costs?		ssified to emp meal income the amount.	been offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? YES 11	(16)	Travel and Transp	ortation included for out-of-state travel?	NO		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,840 Line 10		If YES, attach a	complete explanation. separate contract with the Department	t to provide m		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.		program during c. What percent of	this reporting period. \$ all travel expense relates to transportage logs been maintained? YES			
(8)	Are you presently operating under a sale and leaseback arrangement? NO If YES, give effective date of lease.		e. Are all vehicles times when not	stored at the nursing home during the in use?	-		
(9)	Are you presently operating under a sublease agreement? YES X NO	1	out of the cost r	commuting or other personal use of a eport? ity transport residents to and fr			NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over.	,	Indicate the a	ing transport residents to and ir imount of income earned from p in during this reporting period.			NO
		(17)		performed by an independent certificENRY SCHOLTEN & COMPANY			YES tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 39,447 This amount is to be recorded on line 42 of Schedule V.			that a copy of this audit be included			
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.		out of Schedule V				
		(19)	performed been at	are in excess of \$2500, have legal invitached to this cost report? YES and a summary of services for all archi		-	ices